## WHY IS PHYSICAL RESTRAINT STILL ACCEPTABLE FOR DENTISTRY?

The aftermath of the massive earthquake that destroyed the homes of millions of Haitians was broadcast by television networks worldwide. Newscasts focused on citizens pulling victims from the rubble and on volunteer doctors and nurses treating the severely injured in open courtyards because most of the hospitals and clinics were destroyed. With minimal sterile instruments and supplies, these heroic health care workers sometimes had no alternative other than to amputate gangrenous limbs of victims without anesthesia, just as it was done for centuries before Horace Wells and William T.G. Morton discovered general anesthesia. One heart-breaking newscast showed a screaming child being forcibly held down so her severely lacerated leg could be debrided and sutured without any anesthetic. I wish I could have been there with ketamine or sevoflurane to make that child's terror and pain disappear. How terrible it must have been for her caregivers to have no alternative than to restrain that child for the excruciatingly painful procedure, and for the child to have physically and psychologically endured it.

I thought how fortunate I am to live in a modern country where anxiety, fear, and surgical pain can be comfortably eliminated by advanced forms of anesthesia. I never forcibly restrain any patients for high-quality dentistry performed by my fellow dentists. A big hug given by a parent while I inject intramuscular ketamine or tightly holding a full-face mask for a few seconds until enough sevoflurane is inhaled by a small child snuggled safely in her mother's lap is the extent of restraint with which I am comfortable, even for the most recalcitrant severely mentally impaired adult or resistant pre-cooperative 18-month-old child with severe "bottle caries."

I have always despised physical restraint for dentistry, particularly involving small children and mentally compromised patients. While on an external rotation as a dental student 40 years ago, I witnessed the "hand-over-mouth technique," where the child eventually quieted or perhaps was too hypoxic to fight anymore. I also observed a dentist forcefully restraining a flailing child with a fierce wrestling-style "headlock," where the dentist could only hope that the local anesthetic given under these trying conditions was somewhere close to the target. Now, 4 decades later, has dentistry finally shed its cloak of association with anxiety, fear, and pain? Has dentistry taken full advantage of the precious gift that Wells and Morton gave to our profession? Are the days of hand-over-mouth, headlocks, and other methods of physical abuse to control a young child's behavior an embarrassing relic of the past that hopefully will never be passed on to future generations of dentists and patients? Although restraint might be acceptable in Third World countries, is forceful restraint for dentistry now finally no longer acceptable in modern America? The answer to all these questions is unfortunately an overwhelming "No." To the contrary, it is becoming more common to see reports of dentists using physical restraint devices such as papoose boards or body wrap straight-jackets for prolonged full mouth elective dental restoration in fully conscious children. Apparently not much has really changed in this regard since I was a dental student, except in some cities lucky enough to have the availability of highly trained mobile dentist anesthesiologists who can transform essentially any dental office into a mini–operating room with all the modern equipment and drugs needed to safely administer general anesthesia, so the patient's dentist can provide high-quality comprehensive dental care for patients who need more than local anesthesia and minimal or moderate sedation.

One hundred sixty-five years after dentists discovered anesthesia, why are dentists and parents still willing to allow young children and patients with special needs to be abused by physical restraint when that rarely happens in medical practice other than in a Third World disaster area like Haiti? Myringotomy, hernia repair, and tonsillectomy all can be theoretically accomplished under just local anesthesia, but parents and medical surgeons in developed nations would not stand for forcible restraint of young children for those surgeries with only local anesthesia. If insurance companies denied anesthesia coverage for these necessary medical procedures, or if new, anticompetitive medical board rules suddenly prevented anesthesiologists from being allowed to provide their expert services in ambulatory medical clinics, parents and legislators would be outraged. Why is dentistry different? Why is dentistry the only profession in the civilized world that still accepts forcible restraint for operating on children and patients with special needs when science repeatedly tells us that local anesthesia is frequently ineffective in the oral cavity?

The American Academy of Pediatric Dentistry (AAPD) rightfully addresses the use of physical restraint on its website www.aapd.org/media/Policies_Guidelines/G_BehavGuide.pdf and urges caution in its use. To its credit, the AAPD warns that physical restraint can be physically damaging if the restraint de-

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vice is so tight that it interferes with breathing, especially in the sedated patient, and it warns that physical restraint can be psychologically damaging and may result in the development of dental phobia. Although these admissions are a step in the right direction, a more important question is, Why are we even discussing doing it at all if restraint can be so damaging? AAPD indications for physical restraint include the following:

1. The patient requires immediate diagnosis and/or limited treatment and cannot cooperate because of lack of maturity or mental or physical disability.
2. The safety of the patient, staff, dentist, or parent would be at risk without restraint.
3. The sedated patient requires limited stabilization to help decrease untoward movement.

AAPD contraindications for physical restraint are as follows:

1. The nonsedated patient is cooperative.
2. The patient cannot be immobilized safely because of associated medical or physical conditions.
3. The nonsedated patient with nonemergent treatment requires lengthy appointments.
4. The patient has experienced previous physical or psychological trauma from physical restraint, unless no other alternatives are available.

This last caveat is especially shameful to admit, but in reality, life in the United States for some patients is not much different from that in Haiti regarding use of a restraint. It should not be this way, but the truth is that there is often no reasonable alternative to and no human outcry against forceful restraint for dentistry in our country, *not even if the patient was previously traumatized by restraint*! I believe that other than for very critically emergent or potentially life-threatening cases where, like in Haiti, there are no alternatives to use of restraint, now euphemistically categorized under "protective stabilization," or when the risks of general anesthesia may outweigh the benefits, as in a child with an acute dental injury who has a full stomach, it is inhumane to restrain a nonsedated child or a mentally/physically challenged adult and inflict procedural pain.

Of course, to eliminate the need for restraint, 3 critical changes must occur. First, insurance companies and government-sponsored health care programs must cover deep sedation and general anesthesia for necessary dentistry, as they currently do for medically necessary procedures such as myringotomy and tonsillectomy. Second, many more mobile dentist anesthesiologists are needed to meet the ever-growing need for safe and cost-effective in-office advanced anesthesia services for patients of primary care dentists who need it. Although recent accreditation of 2- and 3-year dental anesthesia residencies has more than doubled their number and will more than triple the number of graduating dentist anesthesiologists in this rapidly growing field, a critical shortage of dentist anesthesiologists will still occur in the near future, and this will limit access to acceptable care. Unfortunately, some states do not have even one, and other states such as Florida make it virtually impossible for dentist anesthesiologists or physician anesthesiologists to provide their expert services in primary care dental offices unless the operating dentist also has sedation or anesthesia training and a permit (64B5-14.005 FS). A general anesthesia–trained primary care dentist supported by 2 dental assistants can simultaneously be both the dental operator and the administrator of the general anesthetic in his or her own office in Florida, but a primary care dentist without sedation or anesthesia training cannot legally hire a mobile dental or medical anesthesiologist, even if supported by a dozen certified critical care nurses, to do just the anesthesia in that office while the dentist concentrates on doing just the dentistry. Such overly restrictive rules certainly do not protect the safety and well-being of our most vulnerable patients but instead leave the average dentist with no alternative but to use physical restraint for young children and patients with special needs.

Finally, the dental profession must do some honest introspection to determine whether centuries of past acceptance of physical restraint represent an acceptable reason to continue the same barbaric practice that was necessary for the little girl in Haiti.

Why is physical restraint still acceptable for elective dentistry in our country? As was stated in previous editorials, it is difficult for people to accept change. Until we stop this brutal, archaic practice, those traumatized children will continue to grow up into adult dental phobics who, despite full-scope dental insurance, will continue to stay away from the dentist for as long as possible until they have pain worse than what they expect the dentist will cause, and dentistry will continue to be the universally recognized symbol for fear and pain, just as it was for centuries before Drs. Wells and Morton. We now must start the process to improve anesthetic availability in dentistry for the sake of our children and grandchildren, so there will be no need for physical restraint to have a cavity filled.

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